PRINTED: 04/13/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MED CARE & MEDICAID SERVICES <u>OMB NO. 0938-03</u>91 STATEMENT OF DEFICIENCIES O(1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09G038 03/25/2009 NAME OF PROVIDER OR SUIPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D.C. HEALTH CARE WASHINGTON, DC 20001 SUMM MRY STATEMENT OF DEFICIENCIES (EACH DEI ICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DATE DEFICIENCY) (W 000) INITIAL COMMENTS {W 000} A manitoring survey was conducted from March 24, 2009, through March 25, 2009. The Plan of Correction for the August 12, 2008 recertification survey, which was submitted by the facility on MAY - 1 2009September 2, 2008, was the focus of this monitoring survey. The facility provided services GOVERNMENT OF THE DISTRICT OF COLUMBIA and support; for six male clients with various disabilities. DEPARTMENT OF HEALTH **HEALTH REGULATION ADMINISTRATION** 825 NORTH CAPITOL ST., N.E., 2ND FLOOR The findings of this survey were based on observations and interviews at the group home WASHINGTON, D.C. 20002 and one day program, and a review of clinical and administrative records including the facility's unusual incident reports. {W 120} 483,410(d)(i) SERVICES PROVIDED WITH (W 120) OUTSIDE SOURCES 8/15/08 The facility must assure that outside services meet the needs of each client. This STANEARD is not met as evidenced by: Based on ot servation, interviews, and record review, the facility failed to ensure that outside services me; the needs of each client, for one of the six clients residing in the facility. (Client #2) The finding includes: The QMRP (ailed to ensure that Client #2' day program used the prescribed adaptive feeding equipment as evidenced below: Observation at Client #2's day program on March 24, 2009, at 12:27 PM revealed Client #2 eating lunch from a plastic storage container and was placed on a riser and using a built up teaspoon. Chservations during the snack and ABORATORY PIDECTOR'S OF PROJUCE REPRESENTATIVES SIGNATURE

Prosicen Any deficiency statement ending with an exterior (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For sursing homes, the above findings and plans of correction are disclossible 14 lays following the data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

TITLE

(XI) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MED CARE & MEDICAID SERVICES

PRINTED: 04/13/2009 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	- 1	ULTIPLE CONSTRUCTION LDING	(X3) DATE S	ETED
l		09G038	B. WIN	le	1	R 25/2009
	PROVIDER OR SUITIVIER			STREET ADDRESS, CITY, STATE 47 QUINCY FLACE, NW WASHINGTON, DC 200	TE, ŽIP CODE	<u> </u>
(X4) ID FREFIX TAG	(EACH DEI ICIENC	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION NE ACTION SHOULD BE D TO THE APPROPRIATE CLENCY)	(XS) COMPLETION DATE
W 124	4:30 PM and 6:20 Client #2 was eating tablespoon, section interview with the conference of the day storage container indicated that during the day program storage commendad severations are seviewed include a three sizes with the facility roust entire facility roust entire facility roust entire facility roust entire client in the client's medicand behavioral state treatment, and of the client's medicand behavioral state treatment.	ence on March 24, 2009, at PM, respectively, revealed by his meals utilizing a regular in plate and a plate riser. Chualified Mental Retardation RP) on March 24, 2009, at 200 AM indicated that she was a program's usage of the plastic for meals. She further are the rest monitoring visit to the observed the client using a spoon and scoop plate. #2's Occupational Therapy dated January 12, 2009, which larch 25, 2009 at 20 AM. The client was eral adaptive feeding supports ided plate, and built up spoon. TECTION OF CLIENTS sure the rights of all clients. It is a minor), or legal guardian, all condition, developmental us, attendant risks of a right to refuse treatment.	W 12	A meeting was he program to revie protocol and adap The day program protocol at all equipment to inclusting equipment to inclusting sided plate a been provided for in his residence QMRP to monduring monthly vis program and at his (Attachment A and	ude a built up spoon, and a plate riser have client # 2's use both and at his program. iter implementation sits to client # 2 day home.	03-26-09

PRINTED: 04/13/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 08G038 03/25/2009 NAME OF PROVIDER OR SUI FLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 SUMMA VAY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID iD (XE) COMPLETION DATE (EACH DEI ICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LBC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 124 Continued From page 2 W 124 The finding includes: The facility failed to ensure that informed consent was obtained from Client #6 and/or his legal guardian prior to the administration of his psychotropic medications. Medication administration observation on March 24, 2009 at 13:00 PM revealed that Client #6 received Sergquel, Inderal, Neurontin and Depakote. Interview with the Licensed Practical Nurse (LPN) on March 24, 2009 at 6:20 PM indicated that the client received the aforementioned medication for his maladaptive behaviors. During the entrance conference on March 24, 2009 at 8:00 AM, an interview was conducted with the Qualified Mental Retardation Professional (QMRP) revealed the client did not Client # 6's general medical Guardian have the capacity to give informed consent for the has signed the consent form for the use use of medications and habilitation services of client# 6's psychotropic medications. The consent form includes the benefits Review of Client #6's record on March 24, 2009. potential side effects associated with at 10;30 AM revealed a psychological 4/17/09 the medicating. OMRP will ensure that assessment dated January 22, 2009, that verified consents are appropriately signed by the the QMRP's statement. According to the assessment Client #6 "is not able to make Guardian. independent decisions concerning his residential or day placements. He lacks the cognitive skills Attachment "C" necessary to understand the implications of such decisions and therefore cannot give his informed consent. He lacks the judgment and insight

makina.

required to make decisions independently." The QMRP further revealed the client had a court appointed guardian to assist him in decision

		AND HUMAN SERVICES & MEDICAID SERVICES				_	FOR	D: 04/13/200 M APPROVE D. 0938-038	D
	T OF DEFICIENCES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LULTIPLE COI LOING	NSTRUCTION		(X3) DATE COMP		
		09G038	B. Wil	··G			03/	R 2 5/2009	
NAME OF F	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP C	ÖDÉ			
D C HEA	LTH CARE				CY PLACE, NW NGTON, DC 20001				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX CF	PROMDER'S PLAN OF CI (EACH CORRECTIVE ACTIO (ROSS-REFERENCED TO TH DEFICIENCY)	ON SHOW	ULDBE	COMPLETION DATE	N
W 124	Continued From pa	ge 3	W	124		·			
W 153	additional interview 2009 at approximate evidence that Clien including the benefit associated with his refuse treatment, he and/or a legally autil 483.420(d)(2) STAI CLIENTS The facility inust en mistreatment, negle injuries of unknown immediately to the a	its medical record and with the QMRP on March 24, ely 10:45 AM falled to provide t #6's treatment needs, its and potential side effects medications, and the right to ad been explained to him norized representative. FT TREATMENT OF sure that all allegations of ct or abuse, as well as source, are reported administrator or to other ce with State law through ires.	` `W 1	53					
	Based on interview a failed to ensure that were reported imme to other officials in a (22 DCMR, Chapter of the six cliants resi #2 and #3) The findings include 1. Review of the increports on March 24 the following injuries been reported to the On March 3, 2009, C	idents and investigative 2009 at 7:45 AM revealed of unknown origin had not Administrator as required:		stay to ge incid cond Coor resid injuri	ential staff on prompt	P was taining aining Manag MRP	unable to the was sement and ting of	03-26-09	
- [iocai hospitiii for seiz	ure activity. The client was 9, 2009. During the client's			gges Soo Attack	7 3.0			

hospital stay, the Qualified Mental Retardation

Please See Attachment "D"

PRINTED: 04/13/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB_NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 09G03B 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 (X4) ID PREFIX SUMMUNTY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DAT DEFICIENCY) W 153 Continued From page 4 W 153 Professional (QMRP) observed abrasions to the client's foreh and and to the top of his head on March 4, 2009. Interview with the QMRP and Program Director on March 25 2009, at approximately 10:30 AM indicated that the abrasions occurred during the client's hospital stay and she could not obtain any information from the hospital staff, regarding the abrasions. Further interview revealed the injury of unknown origin was not reported to the administrator or to the Department of Health (DOH). There was no evidence the facility reported the injury of unknown origin immediately as required. 2. Review of a PCP note dated February 25, Client#3 sustained an injury during his 2009 on March 25, 2009, at approximately 10:00 stay in the hospital. QMRP was unable AM revealed Client #2 has swelling on his 3/26/09 to get any information pertaining to the forehead. incident. In-Service training was conducted by the Incident Management Interview with the QMRP on March 25, 2009, at approximately 10:30 AM revealed she had no Coordinator with OMRP knowledge of the swelling on Client #2's residential staff on prompt reporting of forehead. Interview revealed that the client went injuries of unknown origin to to his PCP on February 25, 2009, for a follow-up. administrator and DOH. Interview revealed the injury of unknown origin 4Hochment O was not reported to the administrator or to the

administrato and DOH.

There was no evidence the facility reported the injury of unk rown origin immediately to the

The facility must have evidence that all alleged

483.420(d)(3) STAFF TREATMENT OF

violations and thoroughly investigated.

DOH.

CLIENTS

W 154

W 154

				FOR	D: 04/13/200 M APPROVE <u>D. 0938-</u> 039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE	SURVEY LETED
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			STREET ADDRESS, CITY, STATE, ZIP O 47 QUINCY PLACE, NW WASHINGTON, DC 20001		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE E APPROPRIATE	COMPLETIO DATE
ontinued From pa	ge 5	W 1	54		
ased on observationiew, the facility fooderus of unknown ients residing in the	on, interview and record liled to thoroughly investigate on origin, for two of the six le facility. (Clients #2 and #3)		·		
Review of the Clarch 25, 2009 at 1 llowing Injuries of a February 25, 20 edical record reve	ient #2's medical record on 10:00 AM revealed the unknown origin: 09, the review of Client #2's		stay in the hospital. QMRI to get any information pert incident. In-Service traconducted by the Incident Coordinator with Qi	was unable aining to the sining was Management MRP and	3/26/0
olessional (QMR) arch 25, 2009 at a vealed that the fac	and Program Director on pproximately 10:30 AM billy did not investigate the		injuries of unknown administrator and DOH.	origin to	
realed Cliant #3 had the top of his hed Program Directout the client sustains spital stay (March 199). Further intendent's hospital stay, promation from the	ad scratches on his forehead ad. Interview with the QMRP or on the same date indicated hed the scratches during his 3, 2009 through March 9, fiew indicated that during the they could not obtain any				
vide evid∌nce tha I been investigate 3.430(a) ()UALIF!!	t the aforementioned incident	AN 150			
	FOR MEDI CARE F DEFICIENCIE: CORRECTION MDER OR SUFFLIER SUMMURY STANDARD CACH DEFICIENCY REGULATO TY OR L CONTINUED FROM particular of unknown lents residing in the findings include Review of the Cl arch 25, 2009 at 1 flowing injuries of the findings include Review with the Qu arch 25, 2009 at 1 flowing injuries of the Cl arch 25, 2009 at 1 flowing injuries of the Cl arch 25, 2009 at 1 flowing injuries of the Cl arch 25, 2009 at 1 flowing injuries of the Cl arch 25, 2009 at 1 flowing injuries of the Cl arch 25, 2009 at 1 flowing injuries of the cl arch 25, 2009 at 1 flowing injuries of the cl arch 25, 2009 at 1 flowing injuries of the cl arch 25, 2009 at 1 flowing injuries of the cl arch 25, 2009 at 1 flowing injuries of the cl arch 25, 2009 at 1 flowing injuries of the cl arch 25, 2009 at 1 flowing injuries of the cl arch 25, 2009 at 1 flowing injuries of the cl arch 26, 2009 a	OGRECTION OGGOSS MIDER OR SUFPLIER CH CARE SUMM FLY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO BY OR LSC IDENTIFYING INFORMATION) Continued From page 5 This STANDARD is not met as evidenced by: assed on observation, interview and record aview, the ficility failed to thoroughly investigate cidents of unknown origin, for two of the six lents residing in the facility. (Clients #2 and #3) The findings include: Review of the Client #2's medical record on arch 25, 2009 at 10:00 AM revealed the flowing injuries of unknown origin: In February 25, 2009, the review of Client #2's edical record revealed the client had swelling on as forehead. The findings include: Review with the Qualified Mental Retardation of essional (QMRP) and Program Director on arch 25, 2109 at approximately 10:30 AM wealed that the facility did not investigate the unies of unknown origin. Observations on March 24, 2009 at 4:30 PM wealed Client #3 had scratches on his forehead of the top of his head. Interview with the QMRP of Program Director on the same date indicated at the client sustained the scratches during his spital stay (March 3, 2009 through March 9, 09). Further interview indicated that during the ent's hospital stay, they could not obtain any commation from the hospital staff, regarding the	FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES: CORRECTION OSGO38 MODER OR SUFFLIER CH CARE SUMMURY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO BY OR LSC IDENTIFYING INFORMATION) Interview and record ordew, the ficility failed to thoroughly Investigate cidents of unknown origin, for two of the six lents residing in the facility. (Clients #2 and #3) the findings include: Review of the Client #2's medical record on arch 25, 2009 at 10:00 AM revealed the fillowing Injuries of unknown origin: In February 25, 2009, the review of Client #2's edical record revealed the client had swelling on as forehead. terview with the Qualified Mental Retardation oriessional (QMRP) and Program Director on arch 25, 2009 at approximately 10:30 AM vealed that the facility did not investigate the unless of unknown origin. Observations on March 24, 2009 at 4:30 PM vealed Client #3 had scratches on his forehead of the top of his head. Interview with the QMRP of Program Director on the same date indicated at the client sustained the scratches during his spital stay (March 3, 2009 through March 9, 09). Further interview indicated that during the ent's hospital stay, they could not obtain any ormation from the hospital staff, regarding the resions. The time of the survey, the facility failed to wide evidence that the aforementioned incident of been investigated.	FOR MEDICARE & MEDICAID SERVICES PREPRIENCIES: ORRECTION (X1) PROVIDERSUPPLERCIA ORGO38 MIDER OR SUFPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING BUILDING BUILDING A TOURIST PLACE, NW WASHINGTON, DC 20001 PREPRICE CROSS-REPERENCED TO THE	FOR MEDI CARE & MEDICALD SERVICES OPERATION OP

Facility ID: 09G038

If continuation sheet Page 6 of 12

-	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 04/13/200 FORM APPROVE OMB NO. 0938-039	
	TOF DEFICIENCILS OF CORRECTION	(X1) PROMOER/SUPPLER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE: COMPL	SURVEY ETED
		09G038	B. WII	NG.		03/	R 25/2009
1	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW		
DUREA	LTH CARE	.՝			WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DE FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	X	Frovider's Plan of Correct (Each Corrective action sho Cross-Referenced to the Appr Deficiency)	ULD SE	COMPLETION DATE
{W 159}	Continued From pa	ige 6	(W 1	59			†
,	integrated, exordina	treatment program must be ated and monitored by a ardation professional.					
	Based on observation Mental Retardation record review, the integration, coordin	is not met as evidenced by: ion, interview with the Qualified Professional (QMRP) and QMRP failed to ensure ation and monitoring of client's or two of six clients residing in #2 and #6)		•			
	The finding: include); ·					
	1. The QMRP failed program us ad the paguipment as evide	d to ensure that Client #2' day rescribed adaptive feeding nced below:					
	March 24, 2009, at eating lunch from a was placed on a risk teaspoon. Observationer at his resider 4:30 PM and 8:20 P Client #2 was eating tablespoon, section Interview with the Querofessional (QMRF approximatily 10:00 unaware of the day)	ent #2's day program on 12:27 PM revealed Client #2 plastic storage container and ar and using a built up tions during the snack and use on March 24, 2009, at M, respectively, revealed I his meals utilizing a regular plate and a plate riser. Lalified Mental Retardation (*) on March 24, 2009, at AM indicated that she was program's usage of the plastic			A meeting was held at client # program to review client # 2's protocol and adaptive equipment. The day program will implem protocol at all times. A equipment to include a built up three sided plate and a plate ris been provided for client # 2's u in his residence and at his program and at his home.	eating t needs. ent the daptive spoon, er have se both rogram. entation	3/24/09
	indicated that during the day program she	meals. She further her last monitoring visit to observed the client using a			(Attachment A and B)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09/3038 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 SUMM ARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (244) 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATURY OR LSC IDENTIFYING INFORMATION) (XII) COMPLETION PRÉFIX TAG PREFIX TAG DATE DEFICIENCY {W 159} Continued From page 7 (W 159) According to Client #2's Occupational Therapy (OT) assessment, dated January 12, 2009, which was reviewed on March 25, 2009 at Client # 6's BSP is being reviewed by approximately 10:00 AM. The client was the psychologist and revised to include recommenced several adaptive feeding supports interventions and strategies to address to include a three sided plate, and built up spoon. nipple pulling, A BSP will be 5/20/09 2. The facility's QMRP falled to ensure that there implemented by were, written instructions for addressing clients maladaptive behavior of pulling on nipples. [See W2401 W 240 483.440(c)(5)(I) INDIVIDUAL PROGRAM PLAN W 240 The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the lacility failed to ensure that there were, written instructions for addressing clients maladaptive behavior of pulling on nipples, for one of the six clients residing in the facility. (Client #6) The finding includes: During evening observations on March 24, 2009 at 4:30 PM, Client #6 was observed pulling on his nipples. A 5:45 PM, Client #6's pocket shirt was torn. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at 6:45 PM revealed that the client had been pulling on his nipples because his shirt was torn and he did not come home from day program with

a tom shirt. Further interview indicated that the client had a Behavior Support Plan (BSP) to address his behavior of nipple pulling.

PRINTED: 04/13/2009

PRINTED: 04/13/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-</u>0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (ACI) DATE SURVEY COMPLETED A. BUILDING R 8. WING 09G03± 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 (X4) ID PREFIX TAG SUMN ARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DE TICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (XE) COMPLETION PREFIX TAG DATE DEFICIENCY) W 240 Continued From page 8 W 240 Review of Client #6's Psychological Assessment dated January 22, 2009 on March 25, 2009 at 9:30 AM revealed, "pulling on nipples" as a targeted maladaptive behavior to be addressed in the client's IISP. Further review of the client's BSP dated February 3, 2009, included interventions to address the behaviors of aggression, clothes tearing and touching people. The BSP however, did not include interventions to Client # 6's BSP is being reviewed by address pulling on his nipples. the psychologist and revised to include interventions and strategies to address Interview with QMRP on March 25, 2009, verified nipple pulling. A BSP will be there was no evidence that the current BSP addressed (locumented interventions to manage implemented by 05-20-09 Client #6's trehavior of pulling on his nipples. The facility failer to develop written interventions to address anti/or manage Client #6's maladaptive behavior. W 263 483.440(f)(ii)(ii) PROGRAM MONITORING & W 263 CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only

The finding includes:

after written consents had been obtained, for one of the six client residing in the facility. (Client #2)

Observation of the morning medication administration on March 24, 2009 at 6:00 PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MECICARE & MEDICAID SERVICES

PRINTED: 04/13/2009 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING.	(X3) DATE (COMPL	SURVEY ETED
ļ		. 09G038	B. WING		03/	R 25/2009
D C HE	PROVIDER OR SI PPLIER		ſ	REET ADDRESS, CITY, STATE, ZIP 47 QUINCY PLACE, NW WASHINGTON, DC 20001	CODE	1008
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	revealed Clent #8 Seroquel, Inderal, Interview with the I after the medicatio aforementic ned mi address the client's During the entrance 2009 at 8:00 AM, a with the QN/RP rev have the capacity to use of medications QMRP's stritement 2009 at 10:30 AM to psychological asse- 2009. According to "does not evidence independent decisk her habilitation plan financial and medica- mental retardation, power of attorney." QMRP, revealed the appointed guardian. Further review of Cl 2009 at approximate the client, in addition medications, also ha dated February 3, 20 of aggression, clothe people. At the time facility failed to provi- obtained for the use medication and Beh medication and Beh medication and Beh medication and Beh	received medications including Neurontin and Depakote. Licensed Practical Nurse (LPN) in administration revealed the edications were used to a maladaptive behaviors. e conference on March 24, in interview was conducted ealed that the client did not of give informed consent for the and habilitation services. The was verified on March 24, hrough review of Client #6's asment dated January 22, the assessment, Client #6's asment dated January 22, the assessment, Client #6 the capacity to make one on her behalf regarding ning, placement, treatment, all matters due to profound He can not execute a durable Continued interview with the at Client #6 had a court ient #6's record on March 24, by at 11:00 AM revealed that in to taking psychotropic and a Behavior Support Plan 209 to address his behaviors as tearing and touching of the survey however, the de evidence that consent was of the psychotropic avior Support Plan (BSP) that sucted to reduce Client #6's refer to W1241	W 331	Client # 6's general m has signed the consent of client# 6's psychotro The consent form inclu /potential side effects the medicating. QMRP consents are appropriate Guardian. Attachment "C"	form for the use pic medications. ides the benefits associated with will ensure that	04-17-09
VV 331 2	483.460(c) 'YURSING	3 SERVICES	W 331		-	

PRINTED: 04/13/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING B. WING 09G038 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 SUMM VARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL! (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (25) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATIORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY W 331 Continued From page 10 W 331 The facility must provide clients with nursing services in accordance with their needs. This STAN()ARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility's nurse failed to ensure nursing services in accordance with clients needs, for one of the six clients residing in the facility. (Client #6) The findings include: The facility's nurse failed to monitor Client #6's blood pressure prior to administering his medication. Observations of the medication administration on An In-Service training for LPN, QMRP March 24, 2009, at 6:00 PM, revealed the and HM was given by nursing director medication rurse prepared and administered on 03/25/09 to ensure the proper med Client #6's medications including Inderal 40 mg BID. Comparison of the medication and ali the medication administration observation and the physician's administration procedures are followed. order dated March 2009, on March 24, 2009, at DC Health Care will ensure continue 7:30 PM revealed that the client's blood pressure training of LPN's on a regular basis. should be taken prior to the administration of Inderal. Further review indicated that Inderal Please See attachment #E should be hald if the cleint's blood pressure was less than 1(0 systolic.

Interview with the medication nurse on March 24, 2009, at approximately 7:50 PM confirmed that she did not take Client #6's blood pressure prior to the administration Client #2's Inderal.

2. The facility's nurse failed to ensure comprehensive treatment services for the maintenance of dental health. [See W358]

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/13/2009 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 096038 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 SUMM ARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (SACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION PREFIX REGULATURY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 331 Continued From page 11 W 331 The facility's nurse failed to ensure that clients received all prescribed medications without error. [See W359] 483.460(k)(2) DRUG ADMINISTRATION W 369 W 369 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANI)ARD is not met as evidenced by: Based on observation and record review, the facility faller to ensure that each client received all prescribed medications without error, for one of the six clients residing in the facility. (Client #6) The finding includes: Observation of the medication administration on An In-Service training for LPN, QMRP March 24, 2009, at 6:00 PM, Client #6 was observed being administered Zocor, Saroquei, and HM was given by nursing director Inderal, Neurontin, and Depakote. Comparison of on 03/25/09 to ensure the proper med the medication administration observation and the and all the medication physician's order dated March 2009 on March 24, administration procedures are followed. 2009 at 7:30 PM revealed that the client was also DC Health Care will ensure continue prescribed Peroxide Solution, five drops to both training of LPN's on a regular basis. ears, three times per month. Interview with the medication nurse at 7:50 PM confirmed that she Please See attachment # E had completed her medication administration without administering Client #6's Peroxide

Solution to his ears.

NO PLAN	NT OF DEFICIENC ES	(X1) PROVIDER/SUPPLE IDENTIFICATION NU HFD03-0028	ericlia Imber:	(X2) MULTII A BUILDING B. WING			LETED R
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	Correction for the A survey, which was a September 2, 2008, monitoring survey.	was conducted from larch 25, 2009. The ugust 12, 2008 receive mitted by the facility provided male residents with	Plan of ruffication lify on				
	and one day program	survey were based o erviews at the group m, and a review of cli is including the facili orts,	home			ı	
{i 022}	3501.5 ENVIRONME SPACE	ENTAL REQ/USE O	OF .	[1 022]		,	8/13/08
1 '	Each window shall be shades or blinds, who good repair.	e supplied with curta ich are kept clean, a	ins, nd in				
	This Statute is not m	et as evidenced by:					
1 374	3519.5 EMERGENCI	ES	1	374			
g n s	After medical services SHMRP shall prompt puardian, his or her no puardian, or the re ponsoring agency of con as possible, folk locumentation no late filter the incident.	ry notify the resident: ext of kin if the reside presentative of the the resident 's atatu wed by written notice	s as				
P-	his Statute is not me ased on staff intervie	et as evidenced by: w and record review	, the				
	ON Administration	SUPPLIES DEBOS OF A	ノ		TITLE	(36	DATE (
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and Plan	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0028		A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE COMP	R
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	GHMRP failed to princtification of paren incidents, for two of the facility. (Resident The findings; include	ovide evidence of the toor guardians of significants and investigated and	gnificant siding in live evenled and not quired: nitted to e client ng the lived to the sobtain garding the to the lived t	1 374	Client#3 sustained an in stay in the hospital. QM to get any information p incident. In-Service conducted by the Incident	ijury during his IRP was unable ertaining to the training was at Management QMRP and upt reporting of a origin to	3/24/

Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XX) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0028 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES (X4) JD PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Ю (XS) COMPLETE DATE (EACH DE TOISN'CY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1374 Continued From page 2 1374 forehead. Interview ravealed that the client went In- Service training was conducted by to his PCP cm February 25, 2009, for a follow-up. the Incident Management Coordinator 3/24/09 interview revealed the injury of unknown origin with QMRP on prompt reporting of was not reported to the administrator or to the injuries of unknown origin to DOH. administrator and DOH. There was no evidence the facility reported the Please See Attachment "D" injury of unknown origin immediately to the administrator and DOH. 1379 3519.10 EMERGENCIES 1379 In addition to the reporting requirement in 3519.5. each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the rusident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP falled to ensure that injuries of unknown origin are reported to the facility's administrator and government agencies as required by DC Regulation [22 DCMR Chapter 35 Section 3919.10], for two of the six residents residing in the facility. (Residents #2 and #3) The findings include: 1. Review of the incidents and investigative reports on Narch 24, 2009 at 7:45 AM revealed the following injuries of unknown origin had not been reported to the Administrator as required:

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0028		(X2) MUL A. BUILDI B. WING		(X3) DATE COMP	ETED R
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	the local hospital for was discharged on client's hospital star Retardation Profess abrasions to the restop of his head on interview with the Con March 25, 2009, indicated that the all resident's hospital sany information from the abrasions. Furtinjury of unknown or administrator or to the (DOH). There was re-	Resident #3 was adnor seizure activity. The March 9, 2009. During, the Qualified Menta sional (QMRP) obsersident's forehead and	e client ng the lived to the lirector 30 AM ling the t obtain garding I the to the	1379			
	2009 on March 25, 2 AM revealed Reside forehead.	note dated February 2009, at approximatel ant #2 has swelling on	y 10:00 hís				
	approximately 10:30 vnowledge of the sworthead. Interview o his PCP on Februanterview revealed the vas not reported to to XOH.	MRP on March 25, 20 AM revealed she had relient #2 revealed that the client ary 25, 2009, for a following of unknown at the administrator or to the administrator or the sign immediately to the province the facility reported the immediately to the sign immediately to the	t no ts nt went low-up, nigin the	142	In- Service training was cond the Incident Management Cowith QMRP on prompt repoinjuries of unknown or administrator and DOH.	ordinator	3 lado

Health Regulation Ad ministration STATEMENT OF DEFICIENC ES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0028 03/25/2009 NAME OF PROVIDER OR SL PPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 SUM URY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIORY OR LISC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XIS) COMPLETE PREFIX TAG TAG DATE DEFICIENCY (I 401) | Continued From page 4 {| 401} {| 401} 3520.3 PROFESSION SERVICES: GENERAL {1401} 8/15/08 **PROVISIONS** Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the A meeting was held at client # 2's day resident. program to review client # 2's eating This Statute is not met as evidenced by: protocol and adaptive equipment needs. Based on observation, interview, and record The day program will implement the review, the GHMRP failed to ensure necessary protocol at all times. Adaptive 2/26/09 adaptive equipment was furnished and equipment to include a built up spoon, maintained, for one of the six residents residing in three sided plate and a plate riser have the facility. (Resident #2) been provided for client # 2's use both in his residence and at his program. The finding includes: QMRP to monitor implementation during monthly visits to client # 2 day The facility 'ailed to ensure that Resident #2 was program and at his home. provided with the recommended adaptive feeding equipment. [See Federal deficiency report (Attachment A and B) citation W4361 1405 3520.7 PROFESSION SERVICES: GENERAL 1405 **PROVISIONS** Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observation, interview and record review, the SHMRP failed to ensure professional services had been provided in accordance with each resident's needs, for two of the six residents residing in the facility. (Resident #2) Health Regulation Administration

AME OF PROVIDER OR 8 IPPLIER D C HEALTH CARE A QUINCY PLACE, NW WASHINGTON, DC 20001 PROVIDER'S PLAN OF CORRECTION (EACH D PRICIPACY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1 405 Continued From page 5 The finding includes: The QMRP falled to ensure that Resident #2's day program used the prescribed adaptive feeding equipment as evidenced below: Observations at Resident #2's day program on March 24, 1000, at 12:27 PM revealed Resident #2 eating it not from a plastic storage container and was pixced on a riser and using a built up teaspoon. Observations during the snack and dinner at his residence on March 24, 2009, at 4:30 PM and 6:20 PM, respectively, revealed Resident #2's was eating his meals utilizing a regular tablespoon, section plate and a plate riser. Interview w th the Qualified Mental Retardation Professional (QMRP) on March 24, 2009, at approximately 10:00 AM indicated that she was unaware of the day program's usage of the plastic storage container for meals. She further		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIE IDENTIFICATION NU HFD03-0028	er/CLIA MBER:	(X2) MUL A. BUILD B. WING			LETED R
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The GMRP falled to ensure that Resident #2's day program used the prescribed adaptive feeding equipment as evidenced below: Observations at Resident #2's day program on March 24, 2009, at 12:27 PM revealed Resident #2's day program in the standard dinner at his residence on March 24, 2009, at 4:30 PM and 6:20 PM, respectively, revealed Resident #2's eating profocol and adaptive equipment needs. The day program will implement the fiser. Interview with the Qualified Mental Retardation Professional (QMRP) on March 24, 2009, at approximately 10:00 AM Indicated that she was unaware of the day program's usage of the plastic storage container for meals. She further indicated that during her last monitorize wide to the day program. QMRP to monitor implementation during monthly visits to client # 2 day program.	PREFIX	(EACH DEFICIENCY	'MUST RF PRECENEN by	Et it t	PREFIX	CROSS-REFERENCED TO THE API	MILBOR	
The QMRP falled to ensure that Resident #2's day program used the prescribed adaptive feeding equipment as evidenced below: Observations at Resident #2's day program on March 24, 1909, at 12:27 PM revealed Resident #2 eating it not from a plastic storage container and was placed on a riser and using a built up teaspoon. Observations during the snack and dinner at his residence on March 24, 2009, at 4:30 PM and 6:20 PM, respectively, revealed Resident #1! was eating his meals utilizing a regular tablespoon, section plate and a plate riser. Interview with the Qualified Mental Retardation Professional (QMRP) on March 24, 2009, at approximately 10:00 AM Indicated that she was unaware of the day program's usage of the plastic storage container for meals. She further indicated that during her last monitoring visits to client #2 day program.	1 405	Continued From page	ge 5		1 405			
observations at Resident #2's day program on March 24, 1:009, at 12:27 PM revealed Resident #2 eating it not from a plastic storage container and was placed on a riser and using a built up teaspoon. Observations during the snack and dinner at his residence on March 24, 2009, at 4:30 PM and 6:20 PM, respectively, revealed Resident #2's was eating his meals utilizing a regular tablespoon, section plate and a plate riser. Interview with the Qualified Mental Retardation Professional (QMRP) on March 24, 2009, at approximately 10:00 AM indicated that she was unaware of the day program's usage of the plastic storage container for meals. She further indicated that during her last monitoring wiet to		The finding includes):					
		oay program used to feeding equipment at Rea March 24, 1909, at 1 #2 eating it not from and was placed on a teaspoon. Observationer at his resident 4:30 PM and 6:20 PM Resident #1! was eatingular tablespoon, sinser. Interview with the Quipment at the Cuipment at the Cu	ne prescribed adaptics evidenced below: sident #2's day progniz:27 PM revealed R a plastic storage contribution and using a busing a busing a busing a busing the snace on March 24, 200 M, respectively, reveiling his meals utilizing section plate and a published Mental Retard) on March 24, 2009, AM Indicated that shoogram's usage of the last monitoring of the last monitoring of the section of the last monitoring of	arn on desident intainer wilt up k and 19, at aled glation at e was 19 further interested to the control of the		program to review client # 2 protocol and adaptive equipme The day program will imples protocol at all times, equipment to include a built u three sided plate and a plate ri been provided for client # 2's in his residence and at his p QMRP to monitor implement	's eating nt needs. ment the Adaptive p spoon, ser have use both program.	3lac/
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to include a three sided plate, and built up spoon. 1422 3521.3 HAE ILITATION AND TRAINING 1422	E	ach GHMftP shall printed assistance to resident selections.	ovide habilitation, tra		22			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION O(3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING HFD03-0028 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 47 QUINCY PLACE, NW D C HEALTH CARE WASHINGTON, DC 20001 SUM WARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY 1422 Continued From page 6 1422 This Statute is not met as evidenced by: Based on chaervation, staff interview and record review, the GHMRP failed to ensure habilitation. training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for one of the six residents residing in the facility. (Resident #6) The finding includes: During evening observations on March 24, 2009 at 4:30 PM. Resident #6 was observed pulling on his nipples. At 5:45 PM, Resident #6's pocket shirt was torn. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at 6:45 PM revealed that the resident had been pulling on his nipples because his shirt was tom and he did not come home from day program with a tom shirt. Further interview indicated that the client had a Behavior Support Plan (BSP) to address his behavior of nipple pulling. Review of Flesident#6's Psychological Assessment dated January 22, 2009 on March 25, 2009 at 9:30 AM revealed, "pulling on nipples" as a targeted maladaptive behavior to be addressed in the resident's BSP. Further review of the client's BSP dated February 3, 2009. included interventions to address the behaviors of aggression, clothes tearing and touching people. The BSP however, did not include interventions to address pulling on his nipples. Client # 6's BSP is being reviewed by Interview with QMRP on March 25, 2009, verified the psychologist and revised to include there was no evidence that the current BSP interventions and strategies to address addressed (locumented interventions to manage nipple pulling. A BSP will be Resident #6's behavior of pulling on his nipples. 3200 implemented by The facility tailed to develop written interventions to address and/or manage Resident #6's Health Regulation Administration STATE FORM

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1 500	3523.1 RESIDENT	'S RIGHTS		1 500			
	protected in accord	dence director shall el sidents are observed lance with D.C. Law 2 applicable District and	and	·			
	passed on Interview GHMRP failed to el were observed and D.C. Law 2-137 (Ri Citizens), this chapt District and Federal	mat as evidenced by: and record review, the nsure the rights of resi protected in accordar ghts of Mentally Retan ier, and other applicable, and other applicable taws, for one of the so	e idents continued with continued co				
1.	The finding includes	:					
F A 2 P D D N	was obtained from Figuardian prior to the osychotropic medication administration 24, 2009 at 6:00 PM eceived Suroquel, in Depakote. Interview Jurse (LPN) on Man	ration observation on I revealed that Reside Ideral, Neurontin and With the Licensed Pra ch 24, 2009 at 620 pc	March of #6		Client # 6's general medical G has signed the consent form for of client# 6's psychotropic medi. The consent form includes the lipotential side effects associate the medicating. QMRP will ensure consents are appropriately signed Guardian.	the use cations. Denefits and with	
b	icaled of all the restored med the entire of med the entire of the ent	ident received the ication for his malada	ptive		Guardian,		
w	ith the Qualified Me	conference on March; Interview was conduct Intal Retardation revealed the resident	ted				; !

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